Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTHWEST TEXAS HOSPITAL 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-08-7247-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: PUBLIC WC PROGRAM Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of $1954.06 for APC # 0154. Allowing this at 140% would yield a fair and reasonable allowance of $2442.58. Medicare would have reimbursed the provider at the base APC rate of $1654.06 for APC # 1054. Allowing this at 140% would yield a fair and reasonable allowance of $2442.58, per the multiply procedure rule the correct allowable would be 50%, which would make it $1221.29 Based on their payment a supplemental payment is still die of $928.19, at this time." [sic]

Amount in Dispute: $2367.03

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent contends that Carrier denied the initial bill due to lack of medical documentation and invoices for implants…Upon receipt of a complete bill, NW TX Hosp was paid based on one procedure for the hernia repair on 03/24/2008 in amount of $1,407.02…Additional payment was then made at Reconsideration in amount of $1,438.84…This additional reimbursement issued on 05/15/08. Total payment was derived using APC 0154 ($1,954.06 + 140% = $2,735.68 minus previous payment of $1,296.84)." "Requestor contacted Carol Ford/Requestor and informed her of the additional payment, as the DCN49032 was not included with the DWC60. She did not have record of payment, so an EOB was faxed to her attention on 06/17/08. She contacted us informing that her records indicated the provider performed two procedures…but we asserted that their billing reflected that only one procedure (incisional hernia repair) was performed." "Ms. Ford ended the conversation by stating that she was going to review the medical information to confirm that two procedures were performed and would either amend the MDR to reflect a request for an additional $928.19 or would, at that point, withdraw the MDR." "Notice of withdrawal has not been received to date." "Carrier respectfully opines that the MDR may not be amended to reflect additional monies owed."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/8/2007 through 11/9/2007	17, W1, W3, 97, W4	Hospital Inpatient Surgery Services	$2367.03	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on June 6, 2008.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:

- 17-Payment adjusted because requested information was not provide or was insufficient/incomplete.
- Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 11 months from the date of service.
- W1-Workers Compensation state fee schedule adjustment.
- W3-Additional payment made on appeal/reconsideration.
- 97-Payment is included in the allowance for another service/procedure.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.

2. The respondent denied reimbursement for the disputed services based upon medical necessity. The Division finds that on the reconsideration EOBs, the respondent did not maintain this denial reason; therefore, a medical necessity issue does not exist and the disputed service will be reviewed in accordance with Division rule at 28 TAC §134.1.
3. Division rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." A review of the submitted medical records supports that the claimant's length of stay exceeded 23 hours; therefore, this admission is defined as an inpatient per Division rule at 28 TAC §134.401(b)(1)(B).
4. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401."
5. Division rule at 28 TAC §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118.00."
6. The hospital admission was from 11/8/2007 through 11/9/2007; therefore, the length of stay was one day.
7. Per Division rule at 28 TAC §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 1 X $1118.00 = $1,118.00. The insurance carrier paid $2,735.68. Therefore, additional reimbursement is not due.
8. Division rule at 28 TAC §133.307(c)(2)(C), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." Review of the submitted documentation finds that the requestor has not completed the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division. Review of the documentation submitted by the requestor finds that the requestor has indicated that the amount billed for the services in dispute is the total for all services charged on the hospital bill; however the documentation does not support that all of the services in dispute were rendered on the dates of service listed on the requestor's *Table of Disputed Services*. The requestor listed the disputed dates of service are 11/8/2007 and 11/09/2007 on the *Table;* the total charges on the bill were for dates of service 11/7/2007, 11/8/2007 and 11/09/2007. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under Division rule at 28 TAC §133.307(c)(2)(C).
9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(C). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	**10/12/2010** Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.